AmeriChoice a UnitedHealth Group Company
County of San Diego

San Diego Low Income Health Program (LIHP) Medical Policies

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This document is periodically updated. Please visit the Low Income Health Program website for the most up-to-date issue:
http://www.sdcounty.ca.gov/hhsa/programs/ssp/county_medical_services/index.html
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Table of Contents

ALLERGY / IMMUNOLOGY

Criteria for Authorization

Treatment or referral for allergic and immunologic conditions is covered for diseases which have failed treatment attempts by the Primary Care Provider (PCP) and continues to be symptomatic.

Allergy/Immunology patients might have, but are not required to have, the following labs/diagnostics in the 3 months prior to scheduling an appointment with the specialist:

- CBC
- ESR
- RAST

Diagnoses treated in the Primary Care Clinic (and not Allergy/Immunology Clinic):
(This list is not intended to be a complete list, but examples of common conditions that should not be referred to Allergy/Immunology unless the patient has failed multiple treatment attempts in the Primary Care Clinic.)

- Intermittent Urticaria
- Contact Dermatitis
- Allergic Rhinitis
- Eczema
- Suspected seasonal allergies

Diagnosis treated in the Allergy/Immunology Clinic:
(This list is not intended to be a complete list, but examples of conditions that are appropriate for referral to Allergy/Immunology Clinic):

- Patients with known Allergic Bronchopulmonary Aspergillosis (ABPA) for management.
- Patients with suspected or proven asthma or cystic fibrosis who have pulmonary infiltrates and peripheral blood eosinophilia
- Anaphylaxis : Individuals with a severe allergic reaction (anaphylaxis) with or without an obvious or previously defined trigger, such as food or medicine.
- Asthma Diagnosis: Patients with uncontrolled or severe asthma (prior severe, life-threatening episode; prior intubation). Consider referral for allergen immunotherapy for asthmatic patients if there is a clear relationship between asthma and exposure to an unavoidable aeroallergen to which specific IgE antibodies have been demonstrated and the following:
    - poor response to pharmacotherapy or avoidance measures
    - unacceptable side effects of medications

  - coexisting allergic rhinitis
  - long duration of symptoms (perennial or major portion of the year)

- Atopic and Contact Dermatitis: Patients whose atopic or contact dermatitis responds poorly to treatment AND interferes with ADLs and employment.
- Occupational Allergic Diseases: Workers in occupations with animal exposure, exposure to food proteins, or other potential allergens who experience chronic skin symptoms and/or respiratory symptoms attributable to the work environment.
- Rhinitis/Sinusitis: Patients with prolonged or severe manifestations of rhinitis with comorbid conditions (eg, asthma or recurrent sinusitis); with symptoms interfering with quality of life, ability to function, or both; who have found medications to be ineffective or have had adverse reactions to medications.
- Urticaria and Angioedema: Patients with chronic urticaria or angioedema (ie, those with lesions recurring persistently over a period of 6 weeks or more), urticarial vasculitis or urticaria with systemic disease (vasculidities, connective tissue disease, rarely malignancies), or chronically recurring angioedema without urticaria.

ASTHMA

Mild intermittent, mild persistent and moderate persistent asthma are managed at the primary care level. Severe asthma or asthma failing primary care treatment may require consultation with an allergy or pulmonary specialist.

Criteria for Authorization

Patient History (one of three)

- asthma symptoms not responding to maximum medical therapy
- Emergency Department (ED) over-use
- hospitalization for asthma exacerbation

AND

Treatment failure (two of four)

- beta-agonists, including long acting
- theophylline
- cromolyn sodium
- inhalation corticosteroids for 3 or more months

OR

Tests

- pulmonary function testing which shows severe reversible disease

BEE STING

The LIHP program covers Bee Sting Allergy kits for a history of definite systemic allergic reaction to bee stings. Referral for consultation and desensitization is based on the following criteria.

Criteria for Authorization

Patient History (one of three)

- respiratory distress, acute urticaria or hypotension after a bee sting (history of anaphylaxis)
- reaction of bee sting is remote from the local reaction, at least 6 inches from sting, including hives (urticaria), respiratory distress or hypotension
- personal risk at work or at home for bee sting exposure

Physical Exam (not required if history is clear or reaction documented by past medical records).

BONE GROWTH STIMULATOR

Although bone stimulators have been used in a variety of clinical settings, the following requirements, adapted from the MediCal program (April 2008 criteria), limit the utilization of osteogenesis stimulator devices.

Criteria for Authorization

Spinal Electrical Device (cervical, thoracic, lumbar, and sacral vertebrae)

(one of the following must be met)

- Failed spinal fusion and a minimum of nine months have elapsed since the last surgery, or
- Following a multi-level spinal fusion surgery involving three or more vertebrae (for example, L3-5, L4-S1, etc.), or
- Following spinal fusion surgery where there is a history of a previously failed spinal fusion at the same site, or
- The patient has one or more risk factors for high risk of spinal fusion failure such as smoking, obesity (BMI>35), diabetes, renal disease, alcoholism, grade II or worse Spondylolisthesis, or other metabolic disease where bone healing is poor

Note: The device should be applied within 30 days as an adjunct to spinal fusion surgery. The patient should use the device for at least two hours per day, and the treatment period continued for nine months (270 consecutive days).

Low-Intensity Ultrasound Device

- Nonunion of a fracture other than the skull or vertebrae, documented by a minimum of 2 sets of radiographs, each including multiple views of the fracture site, separated by a minimum of 90 days, obtained prior to starting treatment with the osteogenesis stimulator, with a written interpretation by a physician stating that there has been no clinically significant evidence of fracture healing between the two sets of radiographs, AND the fracture is not tumor-related,
- OR one of the following for new fractures (not tumor-related):
    - Fresh (<7 days), closed or grade I open, tibial diaphyseal fractures, or
    - Fresh (<7 days), closed fractures of the distal radius (Colles fracture).

Note: An ultrasonic osteogenesis stimulator may not be used concurrently with other noninvasive stimulators.

- If surgery has been performed in an attempt to induce healing of the bone fracture or nonunion via bone graft or internal fixation, the six or twelve month duration begins from the date of the surgery. The surgery date and procedure performed should be included with the TAR.

The device may be authorized for a maximum of one year.

BREAST CANCER – DIAGNOSIS AND TREATMENT

The LIHP program follows California law for the diagnosis and treatment of breast cancer. The following are covered benefits of LIHP.

Treatment for breast cancer shall include coverage for prosthetic devices or reconstructive surgery to restore and achieve symmetry for the patient incident to a mastectomy.

- "mastectomy" means the removal of all or part of the breast for medically necessary reasons, as determined by a licensed physician and surgeon.
- "prosthetic devices" means the provision of initial and subsequent devices pursuant to an order of the patient's physician and surgeon.

BREAST RECONSTRUCTION

The LIHP program covers breast reconstruction only in relation to breast cancer treatment and following or concordant with breast cancer surgery. In rare instances, breast reconstruction may be approved for removal of prosthesis if it is extruding, has ruptured, and causing significant pain and/or pathologic reaction.

Criteria for Authorization

- following or concordant with breast cancer surgery
- treatment associated abnormalities or deformities
- removal of prosthesis for fibrosis or extrusion, as demonstrated by MRI
- replacement of prosthesis if mastectomy due to breast cancer
- nipple reconstruction (for breast cancer)
- breast prosthesis and bras (2), with replacements covered every two years

BREAST REDUCTION SURGERY (REDUCTION MAMMOPLASTY)

The LIHP program covers breast reduction surgery only if it is designated medically necessary, in relation to the therapeutic treatment of a medical condition. Reduction mammoplasty is the removal of breast tissue to reduce size and weight of mammary tissue.

Breast reduction surgery is considered not medically necessary for the following conditions: poor posture, breast asymmetry, pendulousness, problems with clothes fitting properly and nipple-areola distortion and/or psychological considerations.

Mastoplexy or breast lift is a cosmetic reshaping of the breast by removal of skin with or without a small amount of breast tissue and is never covered by LIHP.

Criteria for Authorization

Criteria for Authorization for a Consultation for Therapeutic Reduction Mammoplasty

- Evidence of breasts large enough to cause pain or intertriginous dermatitis
  - Bra size D cup or larger
  - Shoulder bra strap discomfort and demonstrable severe shoulder grooves and/or intractable dermatitis due to bra strap pressure
- AND evaluation of upper back (thoracic and cervical) severe chronic pain (1 year or greater duration) including:
  - Diagnostic testing to evaluate the causes of pain.
  - Evaluations by appropriate consultant(s) from the specialty area(s) of orthopedics, neurology, rheumatology, and/or pain management if the member's PCP requests further assessment of the cause of pain.
- AND documentation of at least 3 months of a reasonable trial of conservative therapy including all of the following:
  - A reasonable trial of NSAIDs (nonsteroidal anti-inflammatory drugs) pain medications and/or muscle relaxants without relief of symptoms.
  - Physical therapy, exercise program, and the use of properly fitting undergarments.
  - BMI less than 30.
  - There is a reasonable prognosis of symptom relief with reduction mammoplasty.

Criteria for Authorization for Therapeutic Reduction Mammoplasty

- Documentation of all of the following is required to substantiate medical necessity for therapeutic reduction mammoplasty:
- A significant Therapeutic Tissue Reduction/Ratio
    - The appropriate amounts (in grams) of breast tissue must be anticipated for removal from each breast, which is based on the patient's total body surface area (BSA) in meters squared. See Table for BSA values to the minimum amount (weight) of breast tissue to be removed per breast.
- AND excessively large pendulous breasts out of proportion to the rest of the individual's normal body structure as demonstrated by measurement, e.g., a suprasternal notch to nipple measurement of greater than or equal to 27cm (average range is 20-24cm)

Minimum Weight of Breast Tissue Removed, per Breast, as a Function of Body Surface Area: **Schnur Sliding Scale**

Body Surface Area (meters squared)	Minimum weight of tissue to be removed per breast (grams)
1.35	199
1.40	218
1.45	238
1.50	260
1.55	284
1.60	310
1.65	338
1.70	370
1.75	404
1.80	441
1.85	482
1.90	527
1.95	575
2.00	628
2.05	687
2.10	750
2.15	819

2.20	895
2.25	978
2.30 or greater	>= 1000

Calculation: BSA=square root of {(height in inches x weight in pounds) / 3131}

BURNS – BURN CENTER POLICIES FOR MAJOR BURNS

The LIHP Program covers up to 5 days of UCSD Burn Center level of treatment and reimbursement. Any extension of this coverage requires authorization.

Criteria for Authorization

- patient has 30% or more 3rd degree burns, or
- patient has inhalation burns requiring intubation, or
- level of care required is intensive for both medical and burn care

CARDIAC TESTING

Prior authorization is not required for Exercise Cardiac Stress Testing or Stress Echocardiogram. Otherwise, approval for Cardiac Testing follows current Milliman Care Guidelines.

CARDIOLOGY

Patients with active heart disease, such as coronary artery disease, heart failure, cardiomyopathy or cardiac arrhythmia may be followed by a cardiologist. Cardiac consultation is approved with clear evidence of a cardiac condition, or for an acutely ill patient with strong suspicion of cardiac pathology. The initial evaluation for cardiac disease is done by the primary care physician (PCP). The PCP may order without a TAR, on a supplemental form, the following studies: EKG, Exercise EKG (stress test), Echocardiogram, Stress Echocardiogram and Holter monitor.

Criteria for Authorization

History (two of five)

- chest pain on exertion
- shortness of breath on exertion
- major risk factors for heart disease, including diabetes mellitus, hypertension, dyslipidemia, smoking, family history, obesity, age over 40 (male) and over 50 (female)
- new onset of weakness and fatigue
- uncontrolled cardiac disease

Physical Exam (one of four)

- cardiac murmur
- abnormal heart sounds
- peripheral edema
- jugular venous distention

AND

Testing (one of five)

- abnormal EKG
- abnormal echocardiography
- abnormal exercise EKG
- cardiomegaly by chest x-ray or echocardiogram
- abnormal holter monitor

CHRONIC FATIGUE SYNDROME

Criteria for Authorization

History (four of four)

- severe unexplained fatigue for > 6 months
- functionally impaired
- identifiable date of onset
- unrelated to psychological stress

AND

Symptoms (three of eight)

- memory or concentration complaints
- sore throat
- tender lymph nodes
- muscle pain
- multi-joint pain
- new pattern of headaches
- unrefreshing sleep
- postexertional malaise lasting more than 24 hours

AND

Treatment (five of five)

- judicious use of medication to ameliorate symptoms
- graded exercise or rehabilitation measures
- hypothyroidism has been ruled out
- depression has been ruled out or treated
- family history of colon cancer
  - three 1° relatives - q 3-5 years from age 20
  - one or two 1° relatives - q 3-5 years from age 40

COMPRESSION STOCKINGS

Criteria for Authorization

Compression stockings are used for a variety of conditions: dependent edema, chronic venous insufficiency, recurrent leg ulcers and for wound management. LIHP will approve compression stockings when critically necessary to restore or maintain function in the patient. When approved, two pair of stockings are allowable with a renewal no sooner than six months.

DENTAL

Criteria for Services Performed in the Dental Clinic and Referrals

The Low Income Health Program only allows for Emergency dental treatment ONLY as a Covered Service. Emergency dental treatment encompasses a treatment course that works to alleviate an enrollee's immediate source of dental pain and infection resulting from pathology or trauma.

The LIHP does not provide comprehensive preventive or restorative dental care, including root canal.

Emergency Care Covered Services

- Site specific x-rays
- Urgent extractions
- Palliative Restoration fillings
- Up to three visits are allowed for each unique dental emergency
- Prior authorization is required for further primary care dental visits

It is expected that in the first visit, the dentist will evaluate the situation and attempt to stabilize the infection. Definitive treatment may occur on the second and/or third visits, depending on the acuity and complexity of the condition. If for some reason the patient cannot be stabilized to perform the necessary procedure by the 3rd visit, a treatment authorization request (TAR) should be submitted for future necessary visits.

Referral to an oral surgeon is limited to complicated/advanced dental care needs that are beyond the scope of practice of a general dentist and necessitates a TAR.

LIHP DENTAL COVERED SERVICES	
ADA Code	**Description**
D0140	Limited Oral Evaluation
D0220	Intraoral - Periapical first film
D0230	Intraoral - Periapical each additional film
D0240	Intraoral - occlusal film
D0250	Extraoral - first film
D0260	Extraoral - first film
D0270	Bitewing, single film
D0272	Bitewings, two films
D2910	Recement inlay
D2920	Recement crown

D5410	Adjust complete denture - maxillary
D5411	Adjust complete denture - mandibular
D5421	Adjust partial denture - maxillary
D5422	Adjust partial denture - mandibular
D6930	Recement fixed partial denture
D7140	Extraction, erupted tooth. First tooth and each additional tooth
D7210	Surgical removal of erupted tooth
D7220	Removal of impacted tooth/soft tissue
D7230	Removal of impacted tooth/partial bony
D7240	Removal of impacted tooth/complete bony
D7250	Surgical removal of residual tooth roots
D7510	Incision and drainage of abscess - intraoral soft tissue
D7520	Incision and drainage of abscess - extraoral soft tissue
D7910	Suture of recent small wounds up to 5cm
D9110	Palliative (Emergency) treatment
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide
D9430	Office visit for observation
D9930	Treatment of complications (post-surgical)

LIHP will honor currently approved TARs for dental treatment in progress. We acknowledge that dental treatment plans may involve procedures and treatments that are performed over a period of time. For previously diagnosed conditions for which TAR approval has been obtained and in which treatment for that diagnosis has commenced before July 1, 2011, all services must be completed by October 1, 2011 and billed to the ASO by December 1, 2011 in order to receive payment for claims.

If dental treatment is in process for a CMS or CI enrollee, and there is follow up needed with a treatment that has not yet been submitted for TAR approval, but is related to a previously approved TAR, such as an interim partial following authorized extractions, all TARs must be submitted to the ASO by July 1, 2011 and the authorized care must be completed by October 1, 2011 and billed to the ASO by December 1, 2011 in order to receive payment for claims.

DERMATOLOGY

Criteria for Authorization

In order to be considered for Dermatology referral, patients may have, but are not required to have, the following labs/diagnostics in the 3 months prior to scheduling an appointment:

- CBC
- ESR
- VDRL
- RPR

Diagnoses treated in the Primary Care Clinic (and not Dermatology Clinic):
(This list is not intended to be a complete list, but examples of common conditions that should not be referred to Dermatology unless the patient has failed multiple treatments in the Primary Care Clinic.)

- Acne
- Warts
- Eczema
- Psoriasis
- Folliculitis
- Scars
- Total Body Checks
- Biopsy of a potentially malignant lesion (non-facial)

Diagnosis treated in the Dermatology Clinic:
(This list is not intended to be a complete list, but examples of conditions that are appropriate for referral to Dermatology Clinic)

- Bullous Pemphigoid
- Pemphigus Vulgaris
- Lupus Erythematosus
- Mycosis Fungoides
- Leprosy
- Epidermolysis Bullosa
- Biopsy of a lesion on the face, eyelid, or other area difficult to access
- Skin Malignancy or suspected skin malignancy

DIABETIC SHOES

Diabetic shoes are frequently recommended to protect the feet of patients with diabetic neuropathy. The LIHP program does not cover customized diabetic shoes for patients with diabetes or any other medical condition unless a specialist is able to indicate that such treatment is critically necessary.

DME (Durable Medical Equipment)

Durable medical equipment is reusable medical equipment such as walkers or wheelchairs. LIHP covers durable medical equipment which is medically necessary when prescribed by a doctor or treating practitioner to be used in the patient's home.

Specifically, DME is defined as equipment that:

- can withstand repeated use;
- is used to serve a medical purpose
- is not useful to an individual in the absence of illness, injury, functional impairment, or congenital anomaly; and
- is appropriate for use in or out of the patient's home.
- not considered disposable, with the exception of ostomy bags
- is necessary to preserve bodily functions essential to activities of daily living; and
- provides therapeutic benefits to a patient in need because of certain medical conditions and/or illnesses.

All requirements of the definition must be met before an item can be considered to be durable medical equipment.

Criteria for Authorization

Medically necessary DME is covered only when:

- medically necessary for the specific member's medical condition or functional limitation
- equipment does not have significant non-medical uses
- is not duplicative of the function of another piece of equipment or device already provided for the member
- is intended for exclusive use of a LIHP member
- is ordered and/or prescribed by a LIHP provider practicing within their scope of practice
- is lowest cost DME item necessary to meet patient's needs

DME normally does not include:

- disposable medical supplies(incontinence supplies)
- devices or equipment used for environmental control (e.g., electric air cleaners, room heaters) or to enhance the environmental setting (e.g., alterations or improvement to real property)

- equipment that basically serves comfort or convenience functions (e.g., physical fitness equipment or trays, back packs)
- equipment that is primarily for the convenience a person caring for the member (e.g., cushion lift chairs)
- self help devices (e.g., safety grab bars)
- Power wheelchairs and scooters are not a covered benefit of LIHP.

Rental versus Purchase

- The decision to rent or purchase DME will be made by LIHP. All DME must be obtained from a vendor that accepts LIHP pricing. If it can be determined that the equipment can be rented for a cost less than purchase payment then the rental will be made. Purchase may be covered only after it is proven through documentation that either:
    - the equipment is unobtainable on a rental basis, or
    - the patient will use the equipment for a long enough period of time to make its purchase more economical than continuing rental fees.
- Generally pieces of equipment such as wheelchairs, hospital beds, and oxygen are rented, and walkers, bedside commodes, and bath benches are purchased.

Repair or Replacement

- Repair of DME purchased by the patient may be covered if this DME item is a covered benefit of LIHP. Repair of rental DME is not covered by LIHP but may be covered as part of the contract or service agreement with the DME vendor.
- Replacement of DME is covered by LIHP only if the item is:
    - medically necessary
    - ordered or prescribed by a LIHP provider
    - provided by a vendor approved by LIHP

- Replacement is not required because of misuse or loss by member.
- The following list includes some covered DME items:
    - Blood glucose monitors
    - Canes (except white canes for the blind)
    - Commode chairs
    - Crutches
    - "Grabbers" or other tools needed for a patient to be independent with ADLs

- Home oxygen equipment and supplies
- Infusion pumps (for IV antibiotics or Enteral Feedings)
- Nebulizers
- Walkers

- Prosthetic devices:
  - Arm, leg, back, and neck braces
  - Artificial limbs and eyes
  - Breast prostheses (including a surgical brassiere) after a mastectomy
  - Ostomy supplies

- The following list includes DME items that are delegated to a LIHP RN to evaluate:
  - C-Pap, Bi-Pap machines and supplies (purchase)
  - Dyna-Splints (patient should have completed a full course of PT –usually 8 sessions or 1 month- AND should be completing the recommended home exercises.)
  - Hospital beds
  - Replacement of DME items.
  - TENS Unit and supplies.
  - Wheelchairs – Manual (RN discretion to rent or purchase)
  - Wound Vacs

DUPUYTREN'S CONTRACTURE

Criteria for Authorization

Referral for this condition is approved in cases in which the disease interferes with work or activities of daily living.

Patient History (both must be present)

- involvement of the palmar and digital fascia
- flexion deformity of the fingers

AND

Physical Exam (both must be present)

- characteristic nodule or cord in the palmar fascia
- metacarpophalangeal joint contracture >30 degrees

EPIDURAL STEROID INJECTION

Criteria for Authorization

Epidural steroid injection is indicated for chronic neck or back pain with radiculopathy.

Patient History

- chronic neck or back pain with radicular symptoms present for at least 3 months, and
- conservative pain management has been used for at least 6 weeks without benefit

Physical Exam

- evidence of neurologic signs (numbness, weakness or reflex changes)

Injections are limited to three in a given 12 month period.

GENETIC COUNSELING

Genetic testing, treatment, or counseling begins with a consultation for Genetic Counseling. LIHP covers Genetic Counseling only under the condition that Genetic testing of the member may change or inform the member's treatment plan.

Criteria for Authorization

Patient History (one of the three)

- Cancer that may be linked to a genetic predilection to other types of cancer, such as Hereditary Breast and Ovarian Cancer.
- A disease in which the diagnosis, severity or manifestation of the disease may be influenced by the genetic typing. For example, Multiple Endocrine Neoplasia type I or II.
- A disease in which the recommendations for treatment may depend on genetic typing. For example, Familial Adenomatous Polyposis.

LIHP does not cover Genetic Testing, Treatment or Counseling for the following:

- Non-medical reasons (e.g., court-ordered tests, work-related tests, paternity tests).
- Non-medically necessary screening to determine carrier status for inheritable disorders when there would not be an immediate medical benefit or when results would not be used to initiate medical interventions/treatment.
- Testing of persons who have no clinical evidence or family history of a genetic abnormality.

GYNECOMASTIA

LIHP does not cover surgery for Gynecomastia unless there is a malignancy.

HEADACHE - MIGRAINES

Criteria for Authorization

The PCP will evaluate and manage most patients with migraines. Referral to a neurologist is approved for a failure to respond to treatment or for positive neurologic findings.

HEARING LOSS

The LIHP program covers referral, testing and treatment for hearing loss which impairs a person's ability to work and handle activities of daily living.

Criteria for Authorization

Patient History (At least one of these is required)

- infection or trauma suggesting a Conductive hearing loss. With infection (otitis media), the hearing loss must be present for at least 2 months
- otosclerosis
- sensorineural hearing loss with:
  - lesion of cochlea
  - tinnitus
  - gait imbalance
  - unilateral hearing loss
- a family history of a genetic hearing loss
- sudden onset of a major hearing loss
- recurrent dizziness with hearing loss
- poor speech discrimination

Physical Exam (At least one of these is present)

- otoscope exam
  - no presence of blood, pus, cerumen plug, or foreign objects (all of which are treated in primary care)
  - abnormal findings of the tympanic membrane or middle ear which suggest a permanent or chronic problem

Tests

- audiogram shows evidence of more than a 30 decibel deficit

Replacement or repair of hearing aid is authorized up to once per 12 month period

Bi-aural hearing aids require visual acuity justification

HEMORRHOIDECTOMY

Criteria for Authorization

LIHP does not cover referral for treatment of external hemorrhoids unless the following criteria are met.

Patient History (any one of these present)

- repeated or persistent prolapse or thrombosis with severe pain
- recurrent bleeding unresponsive to conservative treatment
- thrombosis with severe pain not responsive to warm baths or medications

Physical Exam

- must support history

HEPATOLOGY REFERRAL

Criteria for Authorization

The LIHP program will only approve for referral and treatment of Hepatitis B or C following Milliman Care Guidelines.

Hepatology patients must have the following labs/diagnostics prior to scheduling an appointment:

- Labs within the last 3 months (CMP, Liver panel, CBC with Diff, PT/INR, PTT)
- Serology within the last 3 months:
    1. HBsAb
    2. HBsAG (and if positive)
        a. HBV DNA PCR
    3. HBcAb (IgM / IgG)
    4. HAV Ab (IgM / IgG)
    5. HCV Ab (and if positive)
        a. HCV RNA PCR
        b. HCV Genotype
- Immunologic Studies:
    1. Qualitative Immunoglobulin Panel
    2. Immunoglobulin Panel
    3. ANA
    4. ASMA
    5. ALKM-1
    6. RF
- Diagnostic Studies (if done): (patient to bring copy of the studies, or a CD of the studies, to their hepatology appointment.)
    1. CT
    2. MRI
    3. US
    4. EGD/Colonoscopy
    5. Liver Biopsy

Diagnoses treated at the Hepatology Clinic:
(This list is not intended to be a complete list, but examples of conditions that are appropriate for referral to Hepatology Clinic.)

- Autoimmune Liver Disease (Requires Immunologic Studies)
- Cirrhosis
- Fatty Liver
- Hemochromatosis
- Liver Mass /Cancer (confirmed diagnosis by imaging/biopsy)
- Transaminitis
- Viral Hepatitis

HYPOGONADISM AND TESTOSTERONE REPLACEMENT

LIHP only approves testosterone replacement for therapeutic treatment of a medical condition. Hypogonadism is defined as "inadequate gonadal function, as manifested by deficiencies in gametogeneisis and/or the secretion of gonadal hormones". Hypogonadism may manifest with testosterone deficiency, infertility, or both conditions. Symptoms of hypogonadism depend primarily on the age of the male member at the time of the development of the condition.

LIHP does not provide coverage for treatment for members with a diagnosis of infertility, male erectile dysfunction and/or loss of or decrease of libido under any circumstances.

LIHP may cover treatment for members with conditions of primary hypogonadism, such as Klinefelter syndrome, Mumps Orchitis or Hemochromatosis, or with conditions of secondary hypogonadism, such as Kallman syndrome, Inflammatory disease, or Pituitary disorders.

Criteria for Authorization

Hormone replacement with testosterone preparations for hypogonadism may be considered under the following circumstances:

- Treatment of AIDS Wasting Syndrome
- Osteopenia or osteoporosis as confirmed by Bone Density Study associated with hypogonadism that develops postpubertal as a result of one of the following:
    - genetic syndromes
    - congenital disorders
    - toxic exposures
    - radiation treatment
    - chemotherapy
    - cryptochidism
    - mumps orchitis
    - hemochromatosis
    - autoimmune syndromes
    - testicular trauma
    - secondary to hypothalamic-pituitary tumors
- For post-pubertal hypogonadism testosterone replacement may be considered when the member has:
    - two (2) morning laboratory tests confirming low total testosterone level of less than 200ng/dL on each test.
    - AND Hypogonadal symptoms

- Testosterone replacement therapy is contraindicated in men with prostate cancer, male breast cancer, or untreated prolactinoma. Sleep apnea and polycythemia, which may cause hyperviscosity, are relative contraindications to the use of testosterone therapy.

MEDICAL TRANSPORTATION

Criteria for Authorization

Medical transportation for certified LIHP patients is coordinated in the Medical Management Services Department. There are three categories of medical transportation: Emergent (by ambulance with an ACLS certified team of EMTs), Urgent (transport with a BLS trained team), and Non-Urgent medical transportation (wheelchair van, transport on a stretcher/gurney).

Emergent transportation for medical care (must be documented)

- Ambulance transport to the emergency department when medically necessary (Patient requires the care of a certified EMT during transportation, and/or requires immediate medical attention that can not be obtained by other means.)
- Ambulance transport from one hospital to another to facilitate the prompt receipt of appropriate services, as medically necessary.

Urgent transportation for medical care

- Patient does not require the supervision and services of an EMT or ACLS certified individual during transport.
- Non-emergent medical transport to the Emergency Department for a patient who has been stabilized by the Primary Physician.

Non-Urgent transportation for medical care

- Patient does not require medical supervision during transportation.
- Patient's medical condition makes it unsafe or impossible to be transported in other type of vehicle. (For example, patients who have been casted or fixated in a position that requires a stretcher, patients requiring wheel chair transportation if they are unable to transfer independently from their wheelchair.)

Transportation upon hospital discharge

- Upon discharge from a hospital or acute care facility, the acute care facility is responsible for transporting the patient upon discharge, as needed.

NEPHROLOGY

Criteria for Authorization

Mild renal insufficiency is managed at the primary care level. Referral to Nephrology and follow-up is approved for patients with a serum creatinine of 2.0 or higher or if the estimated GFR is 30 or lower.

Patients considered for nephrology referral must have the following labs/diagnostics in the 3 months prior to scheduling an appointment:

- CBC
- CMP (serum BUN/ Cr, eGFR, Urinalysis (with Micro), Microalbumin
- HgA1c (if diabetic)
- Renal Ultrasound (if warranted)
- 24 hour urine for creatinine and protein
- Blood Pressure measurement

Diagnoses treated in the Primary Care Clinic (and not Nephrology Clinic):
(This list is not intended to be a complete list, but examples of common conditions that should not be referred to Nephrology unless the patient has failed multiple treatments in the Primary Care Clinic.)

- Diabetic or Hypertensive patients with normal microalbumin, serum Cr, and eGFR

Diagnosis treated in the Nephrology Clinic:
(This list is not intended to be a complete list, but examples of conditions that are appropriate for referral to Nephrology Clinic)

- Serum Creatinine of 2.0 or higher in the last 3 months
- eGFR of 30 or lower in the last 3 months

OBSTRUCTIVE SLEEP APNEA (OSA)

Criteria for Authorization

LIHP covers custom-fitted and prefabricated oral appliances as durable medical equipment (DME) for OSA patients who have mild sleep apnea and meet the criteria for coverage of CPAP (see below), but who are intolerant to CPAP.

Patient History: (two of first four)

- chronic loud snoring
- gasping or choking episodes
- excessive daytime sleepiness
- cognitive difficulties
- stable home situation. (required)
- willingness to use C-PAP machine if recommended with electricity available in patient's bedroom (required)

Physical Exam: Detailed examination should be focused on three anatomical regions including the nose, soft palate (oropharynx), and base of the tongue (hypopharynx).

- obesity, including nuchal obesity
- hypertension
- nasopharyngeal narrowing
- BMI > 35

Treatment:

- Oral Surgery only if there is an obstructive lesion that will relieve the problem.
- CPAP

Oral appliances for OSA that are available over-the-counter without a prescription are not covered.

Continuous Positive Airway pressure (CPAP)

CPAP may be considered medically necessary in patients with clinically significant OSA documented by supervised polysomnography and defined as those patients who meet any of the following criteria*:

- An AHI > 15; OR
- An AHI between 5 and 14 with any of the following associated symptoms:

- Excessive daytime sleepiness (as evidence by a pre-testing Epworth score of greater than 10 or other evidence); or
- Impaired cognition; or
- Mood disorders; or
- Insomnia; or
- Documented hypertension; or
- Ischemic heart disease; or
- Type II second degree heart block or pause > 3 seconds or ventricular tachycardia at a rate > 140/minute
- History of stroke.

Member has been counseled on the importance of weight loss and smoking cessation (if applicable) and the impact of OSA.

*The above patient selection criteria were adopted from the Medicare policy for coverage of CPAP. The presence of these conditions above must be documented in the medical record and must be of clinical significance.

CPAP will not be authorized if the patient is not compliant (minimum of 4 hours per 24 hour period) with its use.

Surgical Therapy

- Surgical therapy would be considered for documented OSAS that has failed an adequate trial of CPAP or oral appliance therapy.

- Nasal Reconstruction – septoplasty or turbinate hypertrophy reduction for snoring associated with OSAS would be medically necessary if the nasal obstruction inhibits the optimal use of nasal CPAP.

- Uvulopalatopharyngoplasty (UPPP), Uvulopalatal Flap (UPF), Hyoid Myotony-Suspension (HM), Genioglossus Advancement (GA) or Maxillomandibular Advancement (MMA) – would be medically necessary if a member has documented CPAP failure and the level of obstruction is determined by fiberoptic nasopharyngolaryngoscopy or lateral cepholometric radiograph.

- Members should be evaluated by a craniofacial surgeon, ENT and/or plastic surgeon.

OPTHALMOLOGY/OPTOMETRY

Criteria for Authorization for Vision Loss

Patient History (one of two)

- decreased visual acuity (provide visual acuity)
- ocular pain
- photophobia

Physical Exam (one of four)

- documented vision loss
- corneal opacification
- pupil abnormalities
- suspicious for corneal ulceration

Criteria for Authorization for Pterygium

Referral for surgery is approved only when vision is impaired.

Patient History

- visual interference (provide documentation)

AND

Physical Exam

- extension onto or over cornea to the extent that vision is impaired

OPTOMETRY- COVERAGE FOR GLASSES

Criteria for Authorization

- vision defect by Snellen testing of equal to or > 20/50 or change in any meridian by at least 1.0 Diopter from the previous prescription
- correction required for employment

Changes in Prescription:

- any meridian change by at least 1.0 diopter
- astigmatic correction of .5 diopters or more

Replacement:

- replacement of glasses – once in 12 months if broken, lost or stolen

Not a Benefit:

- reading glasses

ORGAN TRANSPLANTATION

LIHP never covers organ and bone transplant services or services related to getting an organ transplant. LIHP may consider authorization of services related to avoiding rejection and/or medical complications that arise from an organ transplant received when a patient was not on the LIHP program.

ORTHOTICS

Definitions:

Orthotic devices support, align, prevent or correct deformities of a movable part of the body.

Types of Orthotics:

- Foot orthoses: Orthotics are mechanical devices which are placed in a shoe (shoe inserts) to assist in restoring or maintaining normal alignment of the foot, relieve stress from strained or injured soft tissues, bony prominences, deformed bones and joints, and inflamed or chronic bursae (e.g., arch supports).
- Rigid orthoses– prescribed when absolute biomechanical control is necessary
- Semi-rigid orthoses– provide support for abnormal and excessive motion at the subtalar and midtarsal joints
- Soft – used for shock absorption, relief of pressure areas, relief from shear forces
- Ankle-foot orthoses: Ankle-foot orthoses are most commonly prescribed for muscle weakness affecting the ankle and subtalar joints, such as weakness of the dorsi and plantar flexors, invertors, and evertors. Ankle-foot orthoses can also be prescribed for prevention or correction of deformities of the foot and ankle and reduction of weight-bearing forces.
- Hip-knee-ankle-foot orthoses: Hip-knee-ankle-foot orthoses consist of the same components as described for the standard AFOs and KAFOs, with the addition of an attached lockable hip joint and a pelvic band to control movements at the anatomic hip joint.
- Spring-loaded orthotic devices (i.e., dynasplints, JAS splints) - are eligible for coverage when the member is not responding favorably to conventional methods for restoring joint motion such as exercise and/or physical therapy.

Foot Orthotics are medically necessary foot orthotics are covered for diabetic members. Therapeutic shoes (depth or custom-molded) along with inserts medically necessary for members with diabetes mellitus and any of the following complications involving the foot:

- Peripheral neuropathy with evidence of callus formation; or
- History of pre-ulcerative calluses; or
- History of previous ulceration; or

- Foot deformity; or
- Previous amputation of the foot or part of the foot; or
- Poor circulation.

Orthotics are considered medically necessary when **both** of the following criteria are met:

- The orthotic device is medically necessary to support or aid in the treatment of an illness or injury; and
- It is prescribed by a qualified physician.

All medically necessary supplies, adjustments, repairs or replacement of covered orthotic devices are eligible for coverage. Replacement of the orthotic is generally provided under the following conditions:

- after the device's normal life span; or
- following malfunction of the device; or

Rehabilitative foot orthotics following surgery or trauma:

Rehabilitative foot orthotics that are prescribed following foot surgery or trauma when the rehabilitative foot orthotics are covered as part of their post surgical or casting care. In these instances, foot orthotics are considered an integral part of the covered surgical procedure or foot trauma repair.

Spring-loaded orthotics (i.e., dynasplints, JAS splints):

- are not covered when conventional methods of treating a stiff or contracted joint have not been attempted; and
- are not covered for longer than 3 months of use.

Static AFO is considered medically necessary if <u>all</u> of the following criteria are met:

- Plantar flexion contracture of the ankle with dorsiflexion on passive range of motion testing of at least 10 degrees (i.e., a non-fixed contracture); and
- Reasonable expectation of the ability to correct or prevent a fixed contracture in those who may become ambulatory; and
- Contracture is interfering or expected to interfere significantly with the individual's functional abilities; and
- Used as a component of a therapy program that includes passive stretching of the involved muscles or tendons.

If a static AFO is used for the treatment of a plantar flexion contracture, the pre-treatment passive range of motion must be measured with a goniometer and documented in the medical record. There must be documentation of an appropriate stretching program carried out by professional staff (in a nursing facility) or caregiver (at home).

Ankle-foot orthotics (AFOs) are considered medically necessary for ambulatory individuals with weakness or deformity of the foot and ankle who require stabilization for medical reasons and have the potential to benefit functionally.

Knee-ankle-foot orthotics (KAFOs) are considered medically necessary for ambulatory individuals for whom an ankle-foot orthotic is appropriate and additional knee stability is required.

AFOs and KAFOs that are custom-fabricated are considered medically necessary for ambulatory individuals when the basic medically necessary criteria listed above are met and one or more of the following criteria are met:

- The individual could not be fit with a prefabricated AFO; or
- The condition necessitating the orthotic is expected to be permanent or of longstanding duration (more than 6 months); or
- There is a need to control the knee, ankle, or foot in more than one plane; or
- The individual has a documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury; or
- The individual has a healing fracture which lacks normal anatomical integrity or anthropometric proportions.

Repairs and/or Replacement

- Repairs to medically necessary AFOs and KAFOs, due to wear or to accidental damage, are considered medically necessary when they are necessary to make the AFO or KAFO functional.
- Replacement of an AFO or KAFO or component of an AFO or KAFO due to loss, significant change in the individual's condition, or irreparable accidental damage is considered medically necessary if the device is still medically necessary.

Walking boots used to provide immobilization as treatment for an orthopedic condition or after orthopedic surgery are considered medically necessary.

Orthopedic Shoes, Foot Orthotics and other Supportive Devices of the Feet

Orthopedic shoes, foot orthotics or other supportive devices of the feet, are **not** covered except under the following conditions:

- a shoe that is an integral part of a leg brace and its expense is included as part of the cost of the brace. See section below on therapeutic shoes as integral parts of a leg brace.
- therapeutic shoes furnished to selected diabetic members. See section below on therapeutic shoes for diabetes for details.
- rehabilitative foot orthotics that are prescribed as part of post-surgical or post-traumatic casting care.
- prosthetic shoes that are an integral part of a prosthesis. See section below on prosthetic shoes for details.

Therapeutic shoes as integral parts of a leg brace:

Therapeutic shoes if they are an integral part of a covered leg brace and are medically necessary for the proper functioning of the brace. Oxford shoes are usually covered in these situations. Other shoes, e.g., high top, depth inlay or custom-molded for non-diabetic, etc. may also be covered if they are an integral part of a covered leg brace. Medically necessary heel replacements, sole replacements, and shoe transfers are also covered for therapeutic shoes that are an integral part of a covered leg brace. Inserts and other shoe modifications of shoes that are an integral part of a leg brace are covered if they are medically necessary for the proper functioning of the brace. Medically necessary shoe and related modifications, inserts, and heel/sole replacements, are covered when the shoe is an integral part of a leg brace. A matching shoe, which is not attached to the brace and items related to that shoe, are also covered.

Shoes that are billed separately (i.e., not as part of a brace) will not be covered even if they are later incorporated into a brace.

Therapeutic shoes for diabetes:

One of the following per member per calendar year is considered medically necessary:

- No more than one pair of custom-molded shoes (including inserts provided with the shoes) and two additional pairs of inserts; or
- No more than one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes).

The following items are considered medically necessary for persons with diabetes who meet the criteria for diabetic shoes listed above:

Depth shoes with the following characteristics are considered medically necessary when criteria are met:

- Have a full length, heel-to-toe filler that, when removed, provides a minimum of 3/16th inch of additional depth used to accommodate custom-molded or customized inserts; and
- Are made of leather or other suitable material of equal quality; and
- Have some sort of shoe closure; and
- Are available in full and half sizes with a minimum of three widths so that the sole is graded to the size and width of the upper portions of the shoes according to the American standard sizing schedule or its equivalent. (The American standard last sizing schedule is the numerical shoe sizing system used for shoes sold in the United States).

This includes a shoe with or without an internally seamless toe.

Custom-molded shoes with the following characteristics are considered medically necessary when the member has a foot deformity that cannot be accommodated by a depth shoe:

- Constructed over a positive model of the member's foot; and
- Made from leather or other suitable material of equal quality; and
- Have removable inserts that can be altered or replaced as the member's condition warrants; and
- Have some sort of shoe closure.
- This includes a shoe with or without an internally seamless toe.

Modifications of custom-molded and depth shoes: An individual may substitute modifications of custom-molded or depth shoes instead of obtaining a pair of inserts in any combination. The following is a list of the most common shoe modifications available, but it is not meant as an exhaustive list of the modifications available for diabetic shoes:

- Inserts: Medically necessary inserts are those that are total contact, multiple densities, removable inlays that are directly molded to the member's foot or a model of the member's foot and are made of a material suitable for the member's condition.

- Rigid rocker bottoms: These are exterior elevations with apex positions for 51 percent to 75 percent distance measured from the back end of the heel. The apex is a narrowed or pointed end of an anatomical structure. The apex must be positioned behind the metatarsal heads and tapering off sharply to the front tip of the sole. Apex height helps to eliminate pressure at the metatarsal heads. The steel in the shoe ensures rigidity. The heel of the shoe tapers off in the back in order to cause the heel to strike in the middle of the heel.
- Roller bottoms (sole or bar): These are the same as rocker bottoms, but the heel is tapered from the apex to the front tip of the sole.
- Metatarsal bars: These are exterior bars that are placed behind the metatarsal heads in order to remove pressure from the metatarsal heads. The bars are of various shapes, heights, and construction depending on the exact purpose.
- Wedges (posting): Wedges are either of hind foot, fore foot, or both and may be in the middle or to the side. The function is to shift or transfer weight upon standing or during ambulation to the opposite side for added support, stabilization, equalized weight distribution, or balance.
- Offset heels: This is a heel flanged at is base either in the middle, to the side, or a combination, that is then extended upward to the shoe in order to stabilize extreme positions of the hind foot.

Other medically necessary modifications to diabetic shoes include, but are not limited to:

- Flared heels;
- Velcro closures; and
- Inserts for missing toes.

Deluxe features to therapeutic shoes are not covered. A deluxe feature is defined as a feature that does not contribute to the therapeutic function of the shoe. It may include, but is not limited to style, color, or type of leather.

Coverage is provided for a pair of diabetic shoes even if only one foot suffers from diabetic foot disease

Prosthetic shoes:

Shoes that are an integral part of a prosthesis are covered for members with a partial foot. Stock shoes that are put on over a partial foot or other lower extremity prosthesis are not covered.

A prosthetic shoe is a device used when all or a substantial portion of the front part of the foot is missing. A prosthetic shoe can be considered as a terminal device; i.e., a structural supplement replacing a totally or substantially absent hand or foot. Terminal devices such as hooks and prosthetic shoes may be considered prosthetics in place of an artificial hand or foot.

Orthotics are **not** covered under the following conditions:

- When determined to be not medically necessary
- When not prescribed by a qualified physician
- Corrective shoes and arch supports, except for the therapeutic footwear for diabetics
- Upgraded splints may not be medically necessary. (Upgrades include, but are not limited to: decorative items; functionality or features beyond what is required for management of the patient's current medical condition.)
- Over the counter support devices are not eligible for coverage
- Elastic stockings and garter belts are not eligible for coverage
- Orthopedic shoes are not eligible for coverage except when one or both shoes are an integral part of a leg brace.
- Orthotic devices for sport-related activities (example: a knee brace to prevent injury to the knees while playing football). However, an orthotic would be covered for the treatment of the initial, acute, sports-related injury
- For treatment of acute plantar fasciitis
- For treatment of calcaneal spurs (heel spurs)
- For treatment of calcaneal bursitis (acute or chronic)
- For treatment of neurologically impaired feet (including: neuroma; tarsal tunnel syndrome; ganglionic cyst; and neuropathies involving the feet (except diabetic neuropathy), including those associated with peripheral vascular disease, carcinoma, drugs, toxins, and chronic renal disease)
- For treatment of inflammatory conditions (i.e., sesamoiditis; submetatarsal bursitis; synovitis; tenosynovitis; synovial cyst; osteomyelitis; and plantar fascial fibromatosis)
- For treatment of musculoskeletal/arthropathic deformities (including: deformities of the joint or skeleton that impairs walking in a normal shoe; e.g.

bunions, hallux valgus, talipes deformities, pes deformities, anomalies of toes)

- For treatment of vascular conditions (including: ulceration, poor circulation, peripheral vascular disease, Buerger's disease (thromboangiitis obliterans), chronic thrombophlebitis)
- For treatment of back pain, knee pain, pes planus (flat feet), pronation, corns and calluses and hammertoes
- Torsional conditions (e.g., metatarus adductus, tibial torsion, femoral torsion)
- Structural deformities (e.g., tarsal coalitions)
- Hallux valgus deformities
- In-toe or out-toe gait
- Musculoskeletal weakness (e.g., pronation, pes planus);
- More than one device for the same part of the body

PHYSICAL THERAPY, OCCUPATIONAL THERAPY, SPEECH THERAPY

Criteria for Authorization

- PT, OT and ST are approved only for clinical conditions which require these therapies to enable the patient to return to function.
- Milliman Care Guidelines are used to determine approval and length of therapies based on diagnosis and the individual's condition.

Extension of therapy requests must be accompanied by original evaluation and comparative documentation to allow assessment of improvement in function.

PODIATRY

Referral to Podiatry or an Orthopedist for foot problems is covered by LIHP for conditions which are critically necessary for work and/or activities of daily living.

Most common foot problems such as plantar fasciitis and skin conditions are approved for evaluation and treatment by Podiatry after failure of primary care treatment.

LIHP does not cover referral or treatment of toenail fungus infestation (tinea unguum).

Criteria for Referral to a Podiatrist or an Orthopedist

- major foot deformity, including a bunion which is causing pain and inability to work or perform ADLs
- failure of conservative care provided by PCP
- heel spurs – failure to respond to conservative care and requiring an injection
- plantar fasciitis - persistent and severe cases with failure to respond to conservative management

PREVENTIVE HEALTH SERVICES

Criteria for Authorization

The only preventive health services covered by the LIHP program are the immunizations detailed below.

Immunizations:

Adult Immunizations guidelines follow the current MMWR "Recommended Adult Immunization Schedule" presented on the CDC website. Current website address is: http://www.cdc.gov/vaccines/recs/schedules/adult-schedule.htm#hcp

- Coverage, as per MMWR guidelines for healthy adults, is included for Influenza, Td/TdaP, Varicella, and MMR vaccines.
- Coverage, as per MMWR guidelines for "at risk" adults (as defined in the MMWR vaccine schedule), is included for Pneumococcal Polysaccharide, Meningococcal, Hepatitis A and Hepatitis B vaccines.
- Td/Tdap, Varicella, and MMR vaccines will be covered once in the lifetime of each enrollee.
- Vaccines to prevent Human Papilloma Virus and Herpes Zoster (Shingles) are not covered by the LIHP.

PSYCHIATRIC SERVICES

In order to be eligible to receive psychiatric services in the LIHP program, the enrollee must be diagnosed by a LIHP participating provider, within their scope of practice, with a mental health diagnoses specified in the most recent version of the Diagnostic and Statistical Manual (DSM) published by the American Psychiatric Association. The enrollee must also have at least one of the following impairments as a result of the diagnosed mental disorder:

- A significant impairment in an important area of life functioning.
- A probability of significant deterioration in an important area of life functioning.

"Significant impairment" may, for instance, include risk of self-harm or injury to others; loss of ability to provide for food, clothing and shelter; somatization necessitating unnecessary medical visits or procedures; loss of employment; loss of stable psychosocial support system, and risk of further deterioration of mental status or emotional state likely to result in the development of more severe pathology.

The intervention recommended by the enrolled provider, within their scope of practice, must be reasonably calculated to:

- Significantly diminish the impairment; or
- Prevent significant deterioration in an important area of life functioning.

In addition to the three criteria listed above, for an inpatient admission for treatment of a diagnosed mental disorder, one or more of the following criteria may also apply:

The impairment, symptoms or behavior:

- Represent a current danger to self, others or property;
- Prevent the enrollee from providing for, or utilizing food, shelter or clothing;
- Present a severe risk to the enrollee's health and safety;
- Require further psychiatric evaluation or medication treatment that cannot be provided on an outpatient basis.

Criteria for Authorization

PCP should consider ordering the following labs/diagnostics prior to referral:

- TSH
- CBC
- Chemistry Panel

Diagnoses commonly treated by Primary Care Clinicians (PCP):
(This list is not intended to be a complete list, but examples of common conditions that may be treated by the PCP.)

- Mood Disorders, including Depression, Dysthymia
- Anxiety Disorders, including GAD
- Mild or moderate Somatoform Disorders
- Stress Reaction
- Paraphilias
- Adjustment disorders
- Personality Disorders

Additionally, any covered diagnosis may be treated by a PCP, depending on the PCP's level of confidence, competence and behavioral support.

Psychiatric referral and/or treatment is necessary when acuity, severity, and/or psychiatric medication complexity is beyond the scope of the patient's medical home PCP. When risk is acute and imminent, referral to a psychiatrist is almost always indicated. Lesser risk, and/or less imminent risk, may be managed by a PCP, at the PCP's discretion.

Diagnoses commonly treated by Psychiatrists
(This list is not intended to be a complete list, but examples of conditions that may be appropriate for referral to psychiatric providers or teams at County Mental Health, a Mental Health Contracted Agency, and/or an FQHC):

- Complex and Severe Mood Disorders, including Major Depressive Disorder and Bipolar Disorder, prior to stabilization
- Complex and Severe Anxiety Disorders, including OCD, PTSD, Panic Disorders that significantly compromise function
- Psychotic Disorders, including Schizophrenia, prior to stabilization
- Severe Somatoform Disorders
- Dissociative Disorders

Process Guidelines

Mental health benefits to enrollees include:

- Up to 10 days per year of acute inpatient hospitalization (including administrative days) in an acute care hospital, psychiatric hospital, or psychiatric health facility.
- Psychiatric pharmaceuticals included on the LIHP Formulary
- Up to 12 outpatient Mental Health encounters per year. Outpatient encounters include assessment, individual or group therapy, individual or group psychosocial rehabilitation, crisis intervention, medication support and assessment.
- Primary care visits (performed by a primary care provider at a primary care clinic site) during which psychotropic medications are prescribed by the primary care provider (and not by a designated specialty Behavioral Health provider) are considered primary care encounters and billed as such. They do not count as an "outpatient Mental Health encounter" and do not require prior authorization.

All enrollees previously not established with a mental health provider will receive a single visit for completion of a Behavioral Health Assessment by a licensed, registered or waivered mental health clinician, regardless of where they first present (CMH, CMH contracted agency, or FQHC). The timing and the location of the Assessment visit will follow the "no wrong door" policy in order to prevent barriers to mental health care. The assessment does not involve establishment of a client-clinician relationship and does not require prior authorization.

At this visit, a standardbehavioral health assessment form will be completed by the clinician and may be sent to the ASO with the referral (Treatment Authorization Request-TAR) for the initiation of mental health treatment. The care coordinator at the enrollee's primary care home may be contacted by the ASO, as appropriate, to assist in case management.

Referrals for established mental health clients must be processed by the ASO, like any referrals. Maintenance of Continuity of Care will be considered. Guidelines may vary by each CMH region/FQHC partnership. They guidelines may include:	Referral To:	Guidelines
Referral From:		
County Mental Health (3 sites)	CMH	Grandfather: All 12 visits.
County Mental Health (3 sites)	County Mental Health Contracted Agency (4 regions)	According to regional agreements between organizations.

County Mental Health (3 sites)	FQHC Psychiatry	According to regional agreements between organizations.
County Mental Health (3 sites)	FQHC PCP	Stable SMI patients, according to regional agreements between organizations.
County Mental Health Contracted Agency (4 regions)	County Mental Health Contracted Agency (4 regions)	Grandfather: All 12 visits.

SECOND OPINION

Criteria for Authorization

LIHP may authorize a request for a second opinion from the patient or practitioner, or LIHP may suggest a second opinion when any one of the following circumstances are present:

- A more cost-effective treatment option is available.
- Conservative therapy has not been attempted or has not had sufficient time to show results.
- Practitioner or patient disagrees with the diagnosis and/or plan of treatment recommended by the specialist.
- Practitioner or patient is seeking an alternate treatment option that may improve the outcome.
- Patient/practitioner relationship is hindered.
- Geographic and/or other obstacles prohibit patient from accessing care.

SINUSITIS – ACUTE AND CHRONIC

Criteria for Authorization

Referral for acute and chronic sinusitis is only necessary for persistent disease that markedly interferes with work or daily function.

Patient History (one of two)

- persistent obstruction beyond two months which interferes with function
- failure to respond to 2-3 courses of antibiotic therapy

Physical Exam (one of two)

- nasal exam - documenting purulent discharge
- palpable sinus tenderness

Treatment (three of three)

- first and second line antibiotics used for up to 6 weeks
- decongestant therapy for up to 6 weeks
- nasal corticosteroids used for up to 6 weeks without benefit

Diagnostic

- sinus x-rays or CT scan confirm obstruction

TENS UNIT

Criteria for Authorization

May be indicated for patients with chronic pain disorders who are refractory to other treatment and who have demonstrable relief from a TENS trial.

A completed referral must fully document indications for a TENS unit.

- refer patient to PT for TENS trial with two visits AND
- PT to report results to MMS Staff
- Documentation of relief from a TENS trial

TEMPOROMANDIBULAR JOINT (TMJ) DISORDER

Criteria for Authorization

The majority of individuals with TMJ pain have problems of short duration and require little specific intervention to resolve. Even with chronic TMJ complaints surgery is rarely required. There are three categories of conditions relating to this joint, which may cause an individual to seek medical and/or dental treatment. These categories are as follows:

Myofascial Pain – The most common complaint. These members complain of general facial pain in the area of the temporomandibular joints extending laterally over the temporalis and masseter muscles. The complaint is of a burning pain radiating into the cheek and zygomatic area and referred pain extending to the occipital area. This discomfort may also be associated with bifrontal headaches, and cervical and neck pain. Theses member generally have a history of stress, clenching or grinding their teeth, morning tightness and soreness of their neck, jaw or face and soreness when chewing.

Treatment:

- Physical therapy and relaxation techniques e.g. biofeedback, stress reduction therapies, medication, or yoga.
- Referral to a general dentist for construction of a night guard or bite splint can also be helpful.
- Amitriptyline 10-20 mg h.s. or muscle relaxants can also be excellent adjuvant therapy.
- Narcotic medications are contraindicated.
- Anti-inflammatories are generally not helpful.

***These members are not surgical candidates and will potentially get worse if surgical intervention is done.**

Degenerative Joint Disease – The most common form in the temporomandibular joints is osteoarthritis. Osteoarthritis is generally associated with a progressive overloading of the joint due to chronic clenching and grinding or parafunctional habits. These individuals complain of pain located over the joint and pain that is exacerbated with chewing or functioning. They may or may not complain of limited opening, but generally will state that after function the joint begins to hurt. They will complain of crepitus or grinding and

occasional popping in the joints. There may be a history of localized trauma to the jaw or facial area.

Work-up consists of transcranial radiographs or an MRI.

Treatment:

- Physical Therapy as well as treatment with a flat planed orthotic splint and anti-inflammatories.

*__Only when conservative therapies fail should surgical treatment be considered.__

Rheumatoid arthritis and psoriatic arthritis are rare in the temporomandibular joint, but can occur and should be considered.

Internal Derangement – These members are generally younger and will complain of chronic clicking, popping, or locking of the temporomandibular joints with or without pain and limited opening. There may be a history of chronic clenching and grinding or may have a history of acute trauma to their jaw. The chronic clicking and popping are the result of loosening of the posterior attachment which hold the meniscus in position. This may progress to a chronic lock of the joint limiting the range of motion and creating pain when the member opens his/her mouth wide.
Treatment is symptom-based and depends on the amount of pain and dysfunction:

- Simple non-painful clicking and popping is treated conservatively by reducing parafunction and clenching by referral to a general dentist to have a flat planed orthotic splint constructed.
- Amitriptyline or muscle relaxants can be helpful.

***More severe pain and limited mouth opening requires surgical correction.**

Forms of treatment which are <u>not covered</u> include:

- Behavior modification such as Bruxism Appliances/Habit Devices or Biofeedback.
- Repair and Regeneration mechanisms such as maxillomandibular repositioning appliances (occlusal), or oral splints.
- Prosthetic Therapy such as Orthopedic Stabilizing Appliances or Restorative or Prosthodontic Dentistry.

Information necessary for review of TMJ should include:

- primary and secondary diagnoses.
- detailed description of symptoms, including pain, dysfunction, symptom progression.
- known or suspected etiological factors, results of prior treatment interventions, assessment of the patient's past and current disability,
- results of tests, description of mandibular range of motion, TMJ sounds, joint and muscle palpations, pain provocations, diagnostic anesthetic injections, growth anomalies, occlusal status, results of trial of physical therapy etc.
- supporting tests, including radiographs (dental pantographic, TMJ tomograms or arthrograms), cephalometric tracings (when done), photographs, study casts, bone and/or muscle testing results, etc.

TMJ is initially evaluated by primary care to determine the most likely cause. Dental referral should be done before a medical specialist if there is evidence of malocclusion or other dental problems. Other possible referrals include counseling, physical therapy and ENT which are approved based on these criteria:

Patient History (two of four)

- pain or difficulty opening mouth
- jaw locking
- clicking, popping or crepitus sound
- past history of rheumatoid arthritis or osteoarthritis

AND

Physical Exam (one of three)

- presence of facial asymmetry
- limited movement of the jaw
- tenderness and/or crepitation over TMJ joint on palpation

Dental evaluation should be done on most patients.

Failure of Past Treatment (two of three)

- muscle relaxants
- anti-inflammatory agents
- splint/oral appliance

TRIGGER FINGER

Criteria for Authorization

Referral and surgery is approved when correction of the trigger finger is necessary for work or daily function.

Patient History (one of first two AND the third)

- pain at the interphalangeal joint of forefinger or thumb, or
- failure of injectable steroids
- AND
- affecting work (obtain work history) - required

AND

Physical Exam (one of two)

- nodular thickening at the M.C.P. joint
- catching or locking of the P.I.P. joint with extension of finger

UROLOGY

Criteria for Authorization

Urology patients must have the following labs/diagnostics prior to scheduling an appointment (as appropriate):

- Urinalysis (microscopic), Urine Culture
- PSA, CBC, BUN/Cr
- Pathology reports
- Radiology studies as needed (US, IVP, etc.)

Diagnoses treated in the Primary Care Clinic:

- Erectile Dysfunction
- Urinary Tract Infections (uncomplicated)
- Family Planning / Infertility (NCB under CMS)
- Hydrocele unless it causes persistent pain and interference with daily living or with work
- Incontinence unless patient has failed multiple primary care interventions and symptoms significantly interfere with employment or daily activities.

Diagnoses seen at Urology Clinic

Diagnosed Untreated Cancer (confirmed by Imaging Studies)

- Positive Prostate Biopsy
- Renal Mass
- Bladder Tumor
- Testicular Mass
- 2. Suspected/Undiagnosed Cancer
- Gross Hematuria
- Elevated PSA

Acute Stone (confirmed by Imaging Studies)

- Diagnosed Stone
- ER follow up

Urinary Retention

- ER follow up

Previously Treated Cancer Follow up

- Bladder Cystoscopy
- Post Prostatectomy
- Surgery
- Chemo or XRT

Spinal Cord Injured patients

- Catheter Change
- Retained Stents

Complicated Urinary Tract Infections

- 5 or more infections within the last 12 months

Hematuria

- >5 (greater than five RBC on microscopic urinalysis

VARICOSE VEINS

Criteria for Authorization

LIHP may approve referral and surgery for varicose veins that cause major problems with work or daily function, and not for cosmetic purposes.

Patient History (both present)

- associated with severe, constant pain and/or stasis ulceration
- prescription compression stockings have failed after at least a six-month trial

Note: Patient unlikely to require coronary artery bypass grafting in the future.

Physical Exam (one of these present)

- recurrent superficial phlebitis (two or more occasions)
- stasis ulcer that is recurrent (three or more occasions) or not responding to conservative therapy after six weeks

Contraindication: Occlusive arterial disease (moderate to severe)

- recent deep vein thrombophlebitis
- pregnancy
- congenital abnormalities of deep veins

WOUND MANAGEMENT

Criteria for Authorization

Patients with diminished circulation or low oxygen in the blood may have chronic wounds that if not treated aggressively become more complicated. Most wound management is done by primary care, but complicated wounds may require the evaluation and management recommendations of a wound care specialist or clinic. LIHP authorizes such a referral and treatment procedures if critically necessary for wound healing.

Patient History (all must be present)

- chronic ulcers-not healed within 30 days of occurrence
- failure of standard wound therapy
- no measurable signs of healing

Physical Exam

- chronic stage 3 & 4 pressure ulcers, arterial ulcers, diabetic ulcers and venous stasis